IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

January 18, 2008

Robert Breinholt
Creekside Home Health
PO Box 65788
Salt Lake City, Utah 84165

Dear Mr. Breinholt:

This is to advise you of the findings of the Medicare survey at Creekside Home Health which was concluded on January 10, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 31, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

Creekside
Home Health

1246 Yellowstone Ave., Suite C5
Pocatello, Idaho 83201

January 30, 2008

Mr. Patrick Hendrickson
Health Facility Surveyor, Non-Long Term Care
Idaho Department of Health & Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Mr. Hendrickson:

Your survey team conducted a Medicare survey at the Creekside Home Health office in Idaho Falls, which concluded on January 10, 2008. On January 25, 2008, we received the official Statement of Deficiencies. In response to your findings, we have prepared a Plan of Correction. Enclosed is our plan.

We appreciated your survey team's professionalism and willingness to educate us during the survey process. If you have any questions regarding the Plan of Correction, please give me a call at 801-388-7610.

Sincerely,

Susan White

Susan White
Regional Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	01/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HOME HEALTH INC	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification of your agency. Surveyors conducting the review were: Patrick Hendrickson, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patricia O'Hara, RN, HFS Acronyms used in this report: HHA = Home Health Agency RALF = Residential Assisted Living Facility POA = Power Of Attorney RN = Registered Nurse SOC = Start of Care	G 000	RECEIVED FEB 0 1 2008 FACILITY STATE SURVEY	
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the HHA failed to ensure that patients or their POAs had been informed of their rights or there was documented evidence that the HHA had conscientiously tried, within the constraints of the individual situation, to inform the patients or their POAs in writing of their rights. This involved 3 of 8 patient's (# 1, 6, and 8) whose records were reviewed that lived in a RALF. The findings include: The HHA's "Clinical Record Requirements Policy", that was un-dated, stated "The agency	G 101	**TAG: G 101; REGULATION: 484.10 Patient Rights** The director of nursing (DON) held a nurses meeting on 1/22/2008 and in-serviced the nursing staff on patient rights. The DON reviewed the agency's responsibility for informing patients of their rights, including who (e.g. patient and/or POA) to inform; providing a written copy of the bill of rights; and obtaining a signed consent for treatment. Beginning in January 2008, the quality nurses have begun monitoring admission paperwork to ensure that the medical records for all newly admitted patients include a Consent and Notification Form, signed by the patient, POA, or other appropriate patient representative. The quality nurses are using a written audit tool (Intake Checklist) to record their findings. If admission paperwork is missing or incomplete for 5 or more days, the quality nurses will communicate the information to the DON for appropriate follow up.	1/22/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan White	Regional Administrator	1/30/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 101	Continued From page 1	G 101		

will obtain a signed 'Consent for Treatment' form form [sic] the patient and/or the patient's family." On 1/10/08 at 8:30 AM, the HHA's Quality Assurance Officer stated that this was to include a signed copy of the patient's rights.

The HHA's "PATIENT BILL OF RIGHTS AND RESPONSIBILITIES" un-dated stated, "A patient has a right to be informed of their rights and has the right to be notified in writing of their rights and obligations before treatment begins. The home heath agency must provide each patient and family with a written copy of the bill of rights."

The HHA's "Consent and Notification Form", un-dated, said "I voluntarily consent to the service(s) provided by [HHA's Name] .....I hereby consent to the release of information any hospital, skilled nursing facility, assisted living facility, physician, or home health agency...I have received a copy of the Patients Rights and Responsibilities, which includes the State Home Health Agency Hotline...I have received a copy of the Notice of Privacy Practices". This form was to be signed by the patient and/or the patient's family.

* Patient #1 was admitted to the HHA on 10/3/07 and was a current patient at the time of the survey. The patient was a 96 year old female who was admitted to the HHA with diagnoses of an open wound and vertebroplasty. The patient's medical record did not contain a signed copy of the agency's "Consent and Notification Form" that included the patients rights.

On 1/9/08 at 3:15 PM, the admitting nurse confirmed that there was no documented evidence that the patient had signed the agency's

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G 101	Continued From page 2 admitting paper work including a "Consent and Notification Form". * Patient #6 was admitted to the HHA on 12/28/07 and was a current patient at the time of the survey. The patient was a 85 year old female who was admitted to the HHA with diagnoses of muscle weakness and Alzheimer's Disease. The patient had a "Durable Power Of Attorney For Health Care", dated 1/10/05, assigning her granddaughter as her POA. During a home visit at a RALF, on 1/9/07 at 10:15 AM, the patient was observed to be disorientated, confused with impaired judgment and altered perception. The patient's record contained a "Consent and Notification Form", dated 12/28/07, that stated "I voluntarily consent to the service(s) provided by [HHA's Name] .....I hereby consent to the release of information any any hospital, skilled nursing facility, assisted living facility, physician, or home health agency...I have received a copy of the Patients Rights and Responsibilities, which includes the State Home Health Agency Hotline...I have received a copy of the Notice of Privacy Practices". This form was not signed by the patient, the patient's family nor her POA. The form was signed by a RALF staff member. There was no written documentation in the patient's record that the HHA had conscientiously tried, within the constraints of the individual situation, to inform the patient, the patient's family or the patient's POA of their rights. On 1/9/08 at 3:15 PM, the admitting nurse confirmed that the patient, the patient's family, or the patient's POA had not signed the agency's admitting paperwork including the "Consent and Notification Form". She further confirmed, the RALF's staff had signed the paperwork. She	G 101		

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G 101	Continued From page 3 further confirmed that she had not documented her attempts to inform the patient or the patient's POA of their rights. * Patient #8 was admitted to the HHA on 12/6/07 and was a current patient at the time of the survey. The patient was a 86 year old male who was admitted to the HHA with diagnoses of muscle weakness and senile dementia. The patient had a "Durable Power Of Attorney For Health Care", dated 5/7/06, assigning a family member as his POA. During a home visit at a RALF on 1/9/08 at 10:00 AM, the patient was observed to be disorientated, confused with impaired judgment and altered perception. The patient's record contained a "Consent and Notification Form" dated 12/6/07 that stated, "I voluntarily consent to the service(s) provided by [HHA's Name] .....I hereby consent to the release of information any any hospital, skilled nursing facility, assisted living facility, physician, or home health agency...I have received a copy of the Patients Rights and Responsibilities, which includes the State Home Health Agency Hotline...I have received a copy of the Notice of Privacy Practices". This form was not signed by the patient, his family, nor his POA. The form was signed by a RALF staff member. There was no written documentation in the patient's record that the HHA had attempted to inform the patient or the patient's POA of their rights. On 1/9/08 at 3:15 PM, the admitting nurse confirmed that the patient, the patient's family, or the patient's POA had not signed the agencies admitting paperwork including the "Consent and Notification Form". She confirmed the RALF's staff had signed the paperwork. She further confirmed that she had not documented her	G 101		

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G 101	Continued From page 4 attempts to inform the patient or the patient's POA of their rights.	G 101		
G 103	484.10(a)(2) NOTICE OF RIGHTS The HHA must maintain documentation showing that it has complied with the requirements of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure the HHA agency had a policy and procedure in place for who had authority to sign the HHA's admission paperwork for patients who were cognitively impaired and at risk for exploitation. This involved 2 of 2 patients (# 6 and 8) whose records were reviewed, who were cognitively impaired, and at risk for exploitation. The findings include: * Patient #6 was admitted to the HHA on 12/28/07 and was a current patient at the time of the survey. The patient was a 85 year old female who was admitted to the HHA with diagnoses of muscle weakness and Alzheimer's Disease. The patient had a "Durable Power Of Attorney For Health Care", dated 1/10/05, assigning her granddaughter as her POA. During a home visit at a RALF on 1/9/08 at 10:15 AM, the patient was observed to be disorientated, confused with impaired judgment and altered perception. The patient's record contained a "Consent and Notification Form", dated 12/28/07, that stated "I voluntarily consent to the service(s) provided by [HHA's Name] .....I hereby consent to the release of information any any hospital, skilled nursing facility, assisted living facility, physician, or home health agency...I have received a copy of the	G 103	**TAG: G 103; REGULATION: 484.10(a)(2) Notice of Rights** On 1/29/2008, the agency implemented a policy that addresses who has authority to sign the agency's admission paperwork for patients who are cognitively impaired and at risk for exploitation. See attached. The policy was reviewed and approved on 1/29/2008 by the agency's board of directors.	1/29/08

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G 103	Continued From page 5 Patients Rights and Responsibilities, which includes the State Home Health Agency Hotline...I have received a copy of the 'Notice of Privacy Practices'". This form was not signed by the patient, the patient's family nor her POA. The form was signed by a RALF staff member. * Patient #8 was admitted to the HHA on 12/6/07 and was a current patient at the time of the survey. The patient was a 86 year old male who was admitted to the HHA with diagnoses of muscle weakness and senile dementia. The patient had a "Durable Power Of Attorney For Health Care", dated 5/7/06, assigning a family member as his POA. During a home visit at a RALF on 1/9/08 at 10:00 AM, the patient was observed to be disorientated, confused with impaired judgment and altered perception. The patient's record contained a "Consent and Notification Form", dated 12/6/07, that stated, "I voluntarily consent to the service(s) provided by [HHA's Name] .....I hereby consent to the release of information any any hospital, skilled nursing facility, assisted living facility, physician, or home health agency...I have received a copy of the Patients Rights and Responsibilities, which includes the State Home Health Agency Hotline...I have received a copy of the 'Notice of Privacy Practices'". This form was not signed by the patient, his family, nor his POA. The form was signed by a RALF staff member. On 1/10/08 at 8:30 AM, the HHA's Quality Assurance Officer confirmed that the HHA agency did not have a policy and procedure for who had authority to sign the HHA's admission paperwork for patients who were cognitively impaired and at risk for exploitation.	G 103		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF	G 224		

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G 224	Continued From page 6 HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the RN completed the aide care plan and provided supervision for 1 of 5 sampled patients who received care from a home health aide (#1). The findings include: Patient #1 was a 96 year old female who was admitted to the HHA with diagnoses of an open wound and vertebroplasty on 10/3/07. The patient's record contained physician orders, dated 10/29/07, that ordered aide services 2 times a week until the end of the certification period of 12/1/07. The record did not contain a written plan of care to guide the aide from 10/29/07 through 12/1/07. The RN who provided care to patient and was responsible for the supervision of the aide documented, on 11/10, 11/15 and 11/17/07, that the aide had followed the written plan of care. Additionally, the record contained physician's orders, dated 12/3/07, that ordered aide services 1 time a week for 9 weeks. An aide plan of care, dated 12/2/07, documented the aide was to provide the following services on every visit: Shower: Stand/Chair Skin Care: Lotion/Back Rub Assist Dressing Vital Signs (temperature, pulse, respirations and	G 224	**TAG: G 224; REGULATION: 484.36(c)(1) Assignment of Duties of Home Health Aide** The DON held a nurses meeting on 1/22/2008 and in-serviced the nursing staff on their home health aide supervisory responsibilities. The DON addressed providing the aides with written patient care instructions, supervising the care provided, and ensuring that the aides are following the plans of care. On January 28, 2008, the quality nurses revised their audit process for home health aide supervision. The audit will be performed on all clinical records at the time of recertification and at discharge. The audits will include verification of supervisory visits (at least every 14 days); a written plan of care, signed by an RN; and that the home health aide is following the written plan of care. Negative audit findings will be reported to the DON for appropriate follow up.	1/28/08

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G 224	Continued From page 7 blood pressure) Aide visit notes did not provide documentation that the aide provided skin care on 12/5/07, 12/12/07 or 1/4/08. Further, the aide visit notes did not provide documentation of vital signs for 12/5/07, 12/12/07, 12/26/07 and 1/4/08. The RN documented, on 12/6/07, that the aide was following the written plan of care. There was no other documentation contained in the record after 12/12/07 from the RN. 1/9/07 at 12:10 PM, the nurse who was supervising the aide and did the documentation confirmed the findings in the record.	G 224		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification of your agency. Surveyors conducting the review were: Patrick Hendrickson, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patricia O'Hara, RN, HFS Acronyms used in this report: HHA = Home Health Agency RALF = Residential Assisted Living Facility POA = Power Of Attorney RN = Registered Nurse SOC = Start of Care	N 000	RECEIVED FEB 01 2008 FACILITY STANDARDS	
N 016	03.07020. ADMIN. GOV. BODY N016 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. This Rule is not met as evidenced by: Refer to Federal deficiency G 101, as it relates to the failure of the agency to ensure that patients or their POAs had been informed of their rights or	N 016	**TAG N 016; IDAPA 16.03.07.020 ADMINISTRATION-GOVERNING BODY, 04 Patient Rights** The director of nursing (DON) held a nurses meeting on 1/22/2008 and in-serviced the nursing staff on patient rights. The DON reviewed the agency's responsibility for informing patients of their rights, including who (e.g. patient and/or POA) to inform; providing a written copy of the bill of rights; and obtaining a signed consent for treatment. Beginning in January 2008, the quality nurses have begun monitoring admission paperwork to ensure that the medical records for all newly admitted patients include a Consent and Notification Form, signed by the patient, POA, or other appropriate patient representative. The quality nurses are using a written audit tool (Intake Checklist) to record their findings. If admission paperwork is missing or incomplete for 5 or more days, the quality nurses will communicate the information to the DON for appropriate follow up.	1/22/08

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N 016	Continued From page 1 there was documented evidence that the HHA had conscientiously tried, within the constraints of the individual situation, to inform the patients or their POAs in writing of their rights.	N 016	**TAG N 090; IDAPA 16.03.07.023 POLICY AND PROCEDURE MANUAL, 02, j. Patient Rights** On 1/29/2008, the agency implemented a policy that addresses who has authority to sign the agency's admission paperwork for patients who are cognitively impaired and at risk for exploitation. See attached. The policy was reviewed and approved on 1/29/2008 by the agency's board of directors.	1/29/08
N 090	03.07023. POL. & PROC. N090 02. Contents. The manual will, at a minimum, include policies and procedures reflecting the: I. Patient rights. This Rule is not met as evidenced by: Refer to Federal deficiency G 103, as it relates to the failure of the agency to ensure it had a policy and procedure in place for who had authority to sign the HHA's admission paperwork for patients who were cognitively impaired and at risk for exploitation.	N 090		
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to Federal deficiency G 224, as it relates to the failure of the agency to ensure the RN had completed the aide care plan and provided supervision.	N 122	**TAG N 122; IDAPA 16.03.07.024 SKILLED NURSING SERVICES, 05. c.** The DON held a nurses meeting on 1/22/2008 and in-serviced the nursing staff on their home health aide supervisory responsibilities. The DON addressed providing the aides with written patient care instructions, supervising the care provided, and ensuring that the aides are following the plans of care. On January 28, 2008, the quality nurses revised their audit process for home health aide supervision. The audit will be performed on all clinical records at the time of recertification and at discharge. The audits will include verification of supervisory visits (at least every 14 days); a written plan of care, signed by an RN; and that the home health aide is following the written plan of care. Negative audit findings will be reported to the DON for appropriate follow up.	1/28/08

	Number: 1.19
Policy Section: Ethics, Rights, and Responsibilities	**Effective Date:** 1/29/08
Subject: Informed Consent	**Revision Date:**
	Page Number: 1 of 2

CFR 484.10(a) Notice of Rights; 484.10(b) Exercise of rights and respect for property and person; 484.10(c) Right to be informed and to participate in planning care and treatment; IDAPA 16.03.07 Rules for Home Health Agencies: 020 ADMINISTRATION – GOVERNING BODY, 04 Patients' Rights; Utah Administrative Code, R432-700 Home Health Agency Rule, 16 Patients' Rights

POLICY

Upon admission and throughout the course of care, the patient and family/caregiver will be:

(1) Provided with information to make informed decisions regarding the care being performed
(2) Encouraged to participate in the plan of care, as well as for planning for transfer, referral, or discharge
(3) Informed about the outcomes of care, treatment, and services, including unanticipated outcomes
(4) Allowed to refuse all or part of care offered to the extent permitted by law

PURPOSE

To inform the patient and/or appropriate family/caregivers of the risks and benefits associated with care provided in the home and to obtain a written consent for the care provided

PROCEDURE

1. During the admission visit and at follow-up visits, as appropriate, the patient and/or family/caregiver will be given information that describes:
   a. The services and disciplines anticipated to be involved in the care of the patient
   b. The nature and purpose of any proposed care, treatment, service, medications, interventions, and procedures, including written information when available
   c. The potential benefits and risks or side effects, including potential problems related to recuperation
   d. The names of personnel primarily responsible for providing care, treatment, and services and the names of those actually providing care
   e. The likelihood of achieving care, treatment, and service goals

f. Reasonable alternatives to the proposed care, treatment, and service goals
g. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
h. When indicated, any limitations to the confidentiality of information learned from or about the patient

2. If the patient agrees with the proposed care and physician's orders, the patient will be asked to sign the consent form, and the consent form will become a part of the patient's medical record.

   a. A surrogate decision maker may give informed consent for the patient if:
      i. The patient is not physically able to sign the form
      ii. The patient has been judged to be mentally incompetent
      iii. The patient requests that the surrogate decision maker sign the informed consent
   b. The surrogate decision maker may include:
      i. The attorney-in-fact, appointed pursuant to a durable power of attorney for health care
      ii. A court appointed conservator granted authority by the court to make health care decisions for the patient
      iii. Other individuals, as permitted under state law

3. When appropriate, the family/caregiver will be utilized in the care and treatment of the patient. This may include:

   a. Assisting with ordered treatments (with physician or other authorized practitioner approval)
   b. Carrying out activities specified in the plan of care
   c. Encouraging the patient with specified activities
   d. Performing activities when agency personnel are not present

4. The patient may refuse all or part of the care offered.

5. The patient will be informed of the expected consequences whenever treatment or care is refused. The responsible agency representative will document such refusals and notify the patient's physician. Documentation will include the following:

   a. Date and time of the visit or phone contact
   b. Specific care or treatment refused
   c. Description of what the patient was told regarding the consequences of the refusal
   d. Date and time of physician contact
   e. Any resulting physician orders
   f. The patient's response following any explanations